TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Orthopedic Hospital

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-2885-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case."

Amount in Dispute: $2,340.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have re-reviewed the bill for DOS 08/03/2016 and find no additional allowance recommended. The submitted bill was priced @200% CMS' provider specific OPPS rate of $3,586.90, or $7,173.80. CPT codes 29898, 29891 and 97001 priced under CMS' OPPS. CPT code 29895 "Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial" did not price as per NCCI, the procedure code is denied, as included in a more extensive procedure CPT code 29898 "Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive".

Respondent's Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2016	Outpatient Hospital Services	$2,340.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - X936 – CPT or HCPC is required to determine if services are payable
    - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
    - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
    - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
    - X936 – CPT or HCPC is required to determine if services are payable
    - 193 CPT or HCPC is required to determine if series are payable
    - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
    - Z710 – The charge for this procedure exceeds the fee schedule allowance
    - MTPR – Outpatient significant procedures subject to multiple procedure reduction of 50 percent
    - MOPS – Services reduced to the outpatient perspective payment system (OPPS)
    - MX79 – Per NCCI, the procedure code is denied, as included in a more extensive procedure

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $2,340.88 for outpatient hospital services provided August 3, 2016. The requestor states in pertinent part, "…the Hospital contends an additional $2,340.88 remains owed." The respondent states, "We have re-reviewed the bill for DOS 08/03/2016 and find no additional allowance recommended." Therefore, the services in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

2. The relevant portions of 28 Texas Administrative Code 134.403 are:

    (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

        (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

    (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

    (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

        (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

            (A) 200 percent; unless

            (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent

Review of the submitted medical claim finds separate reimbursement for implantables was not requested. Therefore the Medicare facility specific amount is calculated as follows:

- Procedure code J1170 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.

- Procedure code J2270 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.

- Procedure code J2704 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.

- Procedure code 29898 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility wage index of 0.9615 for an adjusted labor amount of $1,382.01. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,340.25. The Medicare facility specific amount of $2,340.25 is multiplied by 200% for a MAR of $4,680.50.

- Procedure code 29891 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 50%. This is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility wage index of 0.9615 for an adjusted labor amount of $1,382.01. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,340.25. The total Medicare facility specific amount, including multiple-procedure reduction, of $1,170.13 is multiplied by 200% for a MAR of $2,340.26.

- Per Medicare CCI edits, procedure code 29895 may not be reported with procedure code 29898 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure.

- Procedure code G8978 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill.

- Procedure code G8979 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill.

- Procedure code G8980 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill.

- Procedure code 97001 has status indicator A, denoting services paid by fee schedule or different payment system from OPPS.

  If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the item on the date provided.

  Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). The Medicare rate for this code for 2016 is $76.83. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $121.93.

- Procedure code C9113 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J0690 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J2250 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J3010 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.

3. The total recommended reimbursement for the disputed services is $7,142.69. The insurance carrier has paid $7,173.80 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 16, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.